APPLICATION FOR LICENSE TO OPERATE AN AMBULATORY OUTPATIENT SURGICAL CENTER PURSUANT TO IC 16-21-2

State Form 9340 (R3 / 3-00)

The undersigned hereby makes application for license to operate an ambulatory outpatient surgical center in the State of Indiana; and in support of this application represents and shows that the owners and operators are able to comply with IC 16-21-2 and its accompanying regulations and will operate and maintain this facility in accordance with said regulations. **THE UNDERSIGNED ALSO CERTIFIES THAT THE CIVIL RIGHTS ACT OF 1961, IC 22-9-1, AS AMENDED, WILL BE COMPLIED IN FULL.**

A. Name and Location of Center:

1. Name _____

2. Location _____
   Street Address City State Zip County

3. For those facilities with off-sites, please attach a list with name, address, phone and fax numbers. Please list days and hours of operation for off-site locations.

4. Telephone number _____ Fax number _____

5. Hours and Days of Operation _____

6. EIN number _____

7. Fiscal year end date _____

8. Medicare Provider number _____

B. Ownership Information:

1. Government _____ Partnership _____ Corporation _____ Other _____
   If "Other", please specify_____

C. 1. Proprietary _____ Non-Profit Organization _____

2. Name of Owner(s): _____

3. Address _____

4. If incorporated, attach a list of Board members' names and addresses.

5. Deemed Status Accreditation: Y / N
   If yes, please give name of accrediting body and effective & expiration dates
   Name: _____
   Effective Date: _____ Expiration Date: _____
   If accredited, please attach a copy of the entity's accreditation approval letter.

-Please see reverse side-

D. Name(s) and address(es) of Hospital(s) with which there is a written agreement for acceptance of referred patients:

_____

Name Location

_____

Name Location

E. Services Provider:

Ancillary Services
1. Laboratory ☐ 2. Radiology ☐
3. EKG ☐ 4.. Pharmacy ☐

Surgical Specialties
1. Cardiovascular ☐ 2. Foot ☐
3. General ☐ 4. Neurological ☐
5. Obstetrics/Gynecology ☐
6. Opthamology ☐ 7. Oral ☐
8. Orthopedic ☐ 9. Otolaryngology ☐
10. Plastic ☐ 11. Thoracic ☐
12. Urology ☐ 13. Other (specify) ☐

F. Number of Operating Rooms _____

I hereby certify under penalties of perjury that the information contained herein is true and accurate.

G. Signature _____
Owner/Chairman

Date _____

Printed Name & Title _____

Signature _____
Facility Administrator

Date _____

Printed Name & Title _____

Return application to:
Indiana State Department of Health
Attn: Acute Care Division – Section 4A
2 N. Meridian Street, Indianapolis, IN 46204